EASTERN PLASTIC SURGERY

NEW PATIENT REGISTRATION

Mr Frank Lin & Dr Neela Janakiramanan

PATIENT DETAILS

Surname... (Mr / Mrs / Miss / Ms / Dr)

Given Names (As listed on your Medicare card) ....

Date of Birth .... Country of Birth ....

Address .... Suburb................................Postcode............

Tel: Home .... Work .... Mobile ....

Email address: ....

Preferred Language (Please circle): English / Other ....

NEXT OF KIN:

Name.. Relationship: .... Tel: ....

REFERRAL DETAILS

Please leave this section blank if it is the same as your referral letter.

Local / Family GP .... Tel: ....

Address .... Suburb.................................... Postcode.............

How did you hear about Eastern Plastic Surgery?

- ❑ GP referral
- ❑ Emergency
- ❑ Newspaper/Media ....
- ❑ Website
- ❑ Other website ....
- ❑ Personal Recommendation ....
- ❑ Other ....

ACCOUNT DETAILS

Medicare Number __ __ __ __ __ __ __ __ __ __ Ref No ____ Exp Date ....

Pension / DVA (Please circle) Card Number ....

Private Health Fund Name: .... Membership No...................................

Please note: If you are a member of NIB, please expect to pay surgical fees in full upfront due to the restrictions imposed by your health fund.

Consultation Fees:	**Initial Consult**	**Subsequent Consult**
Mr Frank Lin	$170.00 (Medicare Rebate $76.15)	$80.00 (Medicare Rebate $38.25)
Dr Neela Janakiramanan	$210.00 (Medicare Rebate $76.15)	$80.00 (Medicare Rebate $38.25)

Aged Pension card holder rates available.

All fees must be settled at the time of presentation of the account.
Procedures undertaken in our rooms will attract a facility fee for materials and instruments.

WORKCOVER *If a Workcover/TAC account is not settled within 30 days it becomes the responsibility of the patient.*

Employer: .... Company: .... Tel: ....

Address .... Suburb............................. Postcode ....

Workcover Insurer .... Claim Number...

Date of Injury .... Injured Area...

TAC - Claim No .... Date of Accident ....

PLEASE TURN OVER & COMPLETE PAGE 2

GENERAL HEALTH QUESTIONNAIRE

Do you have or suffer from any of the following medical problems? (Please tick the correct answer)

MEDICAL CONDITION	YES	NO
Heart Conditions:	❑	❑
Heart Attack	❑	❑
Angina / Chest Pain	❑	❑
Stents / Bypass Surgery	❑	❑
Pacemaker	❑	❑
Asthma	❑	❑
Epilepsy	❑	❑
Stroke or TIA (Mini-stroke)	❑	❑

MEDICAL CONDITION	YES	NO
Diabetes	❑	❑
If 'YES' to Diabetes, is it controlled with: Diet Only ❑ Tablets ❑ Insulin Injection ❑		
DVT / PE (Clots in your legs or lungs)	❑	❑
If 'YES' to DVT/PE: Date of last event? ………………		
Allergies	❑	❑
If 'YES' to Allergies, please list type and reaction: …………………………………………………………		
Latex Allergy	❑	❑

Do you take any blood thinning medication(s)? ❑ YES (Please tick all that apply) ❑ NO

❑ Aspirin / Cartia ❑ Clopidogrel / Plavix ❑ Warfarin ❑ Other ……………………………

Are you a current smoker? ❑ YES, how many cigarettes do you smoke a day? ………………………

❑ NO, never smoked. ❑ NO, but you are an ex-smoker, what year did you quit? ……………………

Do you drink alcohol? ❑ YES, how often? …………………………………… ❑ NO

Please list all your regular medications, including oral contraceptive pill, herbal supplements (if any)

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CLINICAL PHOTOGRAPHY

Clinical photographs and are a valuable resource in providing a high level of health care. Eastern Plastic Surgery routinely uses clinical photos for record keeping, tracking your progress/recovery, and for educating other patients and health care professionals. Your photo constitutes part of your confidential medical records and is stored securely in accordance with Federal and State Legislations. Other than for record keeping, your photos will be de-identified and your name and personal details will never be used.

If you do not consent to clinical photographs to be part of your treatment please inform the Practice Manager.

PRIVACY STATEMENT

In order to comply with Federal and State Privacy Legislations, we require your consent to collect personal information about you. Information collected is used for the main purpose of providing quality health care and may be used for administrative and billing purposes. It may be disclosed to others involved in your health care, including, but not limited to, other treating doctors, hospitals, health care related services, medical diagnostic services and your GP/referring doctors.

I have read the above information and give consent to the collection of my personal information by Eastern Plastic Surgery.

Signature of patient ……………………………………………… Date………………………………

Print name of patient ……………………………… If other, relationship with patient ………………………